

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005085	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/12/2013
NAME OF PROVIDER OR SUPPLIER PARKVIEW LAGRANGE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 207 N TOWNLINE RD LAGRANGE, IN 46761		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>JCAHO Surveyor: 33212 Facility Number: 005085</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey 11/11-12/2013</p> <p>Date of ISDH off site review - 1/23/2014</p> <p>Reviewer/Surveyor -Nancy Otten, RN, PHNS</p> <p>Based on review of the 11/11-12/2013 JCAHO Accreditation Survey Report, it has been determined that Parkview LaGrange Hospital meets the requirements for Hospital Licensure in Indiana for 2013.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE